STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155245	B. WING		10/24/2012
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CODE	
				0 E 86TH ST	
CASTLE	TON HEALTH CAF	RECENTER	IND	IANAPOLIS, IN 46256	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	BEI ICIENCI )	DATE
10000					
	This visit was fo	or the Investigation of	F0000	Submission of this Plan of	
	Complaint IN00	_		Correction shall not constitut	e or
	F			be construed as an admissor	-
	Complaint IN00	0117917-Substantiated.		Castleton Health Care Center the allegations contained in the	
	•	eficiencies related to the		survey report are accurate of	
		cited at F279 and F314.		reflect accurately the provision	ons
				of Nursing Care and services	
	Survey dates: (	October 22, 23, 24 2012		the residents of Castleton He Care Center.	eaith
				oure center.	
	Facility number 000149				
	Provider numbe	er 155245			
	AIM number 10	00266840			
	Survey team: C	Chuck Stevenson, RN			
	Census bed type	<del>2</del> :			
	SNF/NF: 55				
	Total: 55				
	Census payor ty	pe:			
	Medicare: 11				
	Medicaid: 36				
	Other: 8				
	Total: 55				
	Sample: 5				
	These deficienc	ies reflect State findings			
	cited in accorda	nce with 410 IAC 16.2.			
	Quality review	completed on October 29,			
	2012 by Bev Fa	ulkner, RN			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000149

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM	TE SURVEY  MPLETED  24/2012	
	ROVIDER OR SUPPLIE	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 00UZ11

Facility ID: 000149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155245	B. WIN	3		10/24/	2012
	ROVIDER OR SUPPLIER			7630 E	ddress, city, state, zip code 86TH ST APOLIS, IN 46256		
(X4) ID	SUMMARY S'	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	PLANS A facility must use assessment to de the resident's con.  The facility must of care plan for each measurable object meet a resident's mental and psychidentified in the control of the care plan must that are to be furnithe resident's high mental, and psychemical, and psychemical under §4 that would otherw §483.25 but are resident's exercis including the right §483.10(b)(4).  Based on interviting facility failed plan for preventing a resident who would until after the respressure sores for reviewed for care (Resident B).  Findings include	e the results of the evelop, review and revise in prehensive plan of care.  develop a comprehensive in resident that includes ctives and timetables to medical, nursing, and associal needs that are imprehensive assessment.  Inst describe the services inshed to attain or maintain thest practicable physical, thosocial well-being as 183.25; and any services inse be required under not provided due to the e of rights under §483.10, at to refuse treatment under the ew, and record review, and record review, and record review, and record review in the develop a health care on of pressure ulcers for ras at risk for pressure diagnoses and mobility sident had developed in 1 of 3 residents in a sample of 5.	F02	79	It is the intent of this facility that all residents have a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. Describe what facility did to correct the alleged deficient practice for extending the deficiency Resident B no longer resides at the facility. Decribe how the facility reviewed all clients in the facility that could be affected by the same alleged deficient.	e ach at	11/12/2012
	on 10/22/12 at 1	000 p.m.			facility that could be affected b the same alleged deficient	У	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 00UZ11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00			COMPLETED	
		155245	B. WIN			10/24/	2012	
		l .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	I		
NAME OF F	PROVIDER OR SUPPLIER	t .						
CASTLE <sup>-</sup>	TON HEALTH CAR	E CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256					
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	· 	1	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	Diagnoses inclu	ded, but were not limited			practice, and state, what actio	ns		
	to, diabetes mellitus, hypertension,				the facility took to correct			
	· ·	of colon cancer, a			the alleged deficient practice f			
		·			any resident the facility identifi	ied		
		ression fracture of the			as being affected. 1. Skin			
		of hip fracture with open			assessments were completed all residents to assess for any			
		ternal fixation, agitation,			areas of skin break down. 2. A			
	gastro esophagea	al reflux disease, and			Braden Scale was completed			
	respiratory distre	ess.			all residents to assess their ris			
					for skin breakdown or pressur	е		
	An initial Minim	num Data Set assessment,			ulcers. 3. Care Plans were			
	dated 9/29/12, indicated Resident B was				reviewed and updated as	-41-		
	· · · · · · · · · · · · · · · · · · ·	aired, had trouble			appropriate for all residents win			
	1 2 1	ad physical and verbal			high risk for potential breakdo			
	_	* *			4. Treatment orders for reside			
		ed toward others, did not			with current skin breakdown w			
		otally dependent on staff			reviewed for efficacy and			
	for bed mobility				changed as appropriate. 5.			
		owel and bladder, and			Progress notes from Wound C			
	required extensive	ve staff assistance for			Consultants were reviewed an			
	activities of dail	y living.			recommedations implemented appropriate. 6.	1 45		
					C.N.A. Assignment Sheets we	ere		
	An "Admission ]	Nursing Assessment,"			updated as appropriate. 7. Sta			
		ne date of Resident B's			were in-serviced on cause and			
		facility, indicated			prevention of skin			
		s to the right hip. No			breakdown presented by Wou			
	~				Care Consultants staff and the	9		
	_	other skin concerns were			facility's D.O.N./designee. 8. Licensed nursing staff were			
	documented on a	aamission.			in-serviced on proper measuri	na.		
					staging and treatments of wou			
		ission Care Plan, dated			by Wound Care Consultants s			
	9/10/12, contain	ed no care plan for risk			and facility D.O.N./designee.			
	for skin breakdo	wn or pressure ulcers.			Describe the steps or systemic			
		-			changes the facility has made			
	Nurse's notes for	Resident B on 9/30/12 at			ensure that the alleged deficie	ent		
		cated "An area of about			practice does not recur. 1.  All new admission and			
	_				re-admission charts will be			
	3.4 x (umes) 3 c	m (centimeters) was	1		1.5 daminosion silanto will be			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155245	B. WIN			10/24/	2012
NAME OF P	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
CACTIE		E CENTED	7630 E 86TH ST				
	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	reviewed during the		DATE
		er buttock" Resident			facility Morning Meeting		
		contained no other			(Monday-Friday) by the		
		condition, including			D.O.N./designee for proper		
	assessment and/o	or treatment.			completion of assessments an		
					care plans. 2. C.N.A. Assignm	nent	
	A "Skin Assessn	nent Verification" form,			Sheets will be updated on an on-going basis as		
	dated 9/30/12, in	ndicated Resident B had a			needed/appropriate. 4. Resul	ts	
	Stage 11 pressure	sore to her sacral area			of chart audits will be		
	measuring 3.4 by	y 3.0 centimeters.			presented by D.O.N./designee		
	Treatment was indicated to be "Calmo q shift" (calmoseptine ointment every shift).				QA Committee during monthly		
					QA Meetings for completion.		
	No other treatme	ent or intervention was					
	noted.						
	A care plan date	ed 10/02/12, indicated					
	*	sk for developing a					
	pressure ulcer"						
	pressure dicer						
	The record conta	nined no care plan for the					
		a pressure sore as					
	•	Skin Assessment					
	Verification form	11 uateu 9/30/12.					
	A 11337 a 4 D	wasa Nata II data 1					
	_	ress Note," dated					
		eted by Advanced					
		Vound Care Specialist					
	indicated:						
	"Wound Locatio	n: Sacrum.					
	Measurements: 8	3.0 by 9.0 by 0.1					
	centimeters.						
	Etiology (Type):	Pressure					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 00UZ11

Facility ID: 000149

If continuation sheet Page 5 of 14

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE C	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  24/2012
		155245	B. WING			24/2012
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>		ADDRESS, CITY, STATE, ZIP C	CODE	
CASTLE	TON HEALTH CAR	E CENTED		E 86TH ST NAPOLIS, IN 46256		
				NAFOLIS, IIN 40230		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
1710	REGGE/110K1 OK	LEGE IDENTIFICATION OR METHOD TO	1710			DATE
	Stage: Unstageal Injury)	ble/DTI (Deep Tissue				
	Type of Tissue:	RedFragile				
	Diagnosis/Plan·	Unstageable-DTI-				
	1	efs in bed. Upgrade				
	mattress"					
	During an interv	riew with the Director of				
	_	.) on 10/24/12 at 2:30				
		ed that care staff were				
		ot use briefs on residents				
	in bed, but that t	here was no				
	documentation of	of specific instructions to				
	not use briefs for	r Resident B while in bed,				
	and no documen	tation of whether this had				
	been done. She a	also indicated that				
	Resident B's mar	ttress had not been				
	upgraded from the	he facility's standard foam				
	mattress.					
		ord contained no				
		rning or repositioning				
		g an interview on				
		p.m., the D.O.N.				
		ility did not document the				
		schedules for residents at				
	_	sores, either as a				
		r or as a nursing measure.				
	She indicated the	ere was no place in the				
		designated to document				
	turning or reposi	itioning as performed.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 00UZ11

Facility ID: 000149

If continuation sheet

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	OF CORRECTION  OF CORRECTION  155245	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM 10/2	TE SURVEY PLETED 24/2012		
	PROVIDER OR SUPPLIER TON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
TAG	She indicated CNA assignment sheets noted "Turn Q 2 hr" (Turn every 2 hours) and it was "assumed" that staff would know to turn residents who were at risk for pressure sores.  2. A facility policy, dated 8/14/2008, titled "Comprehensive Care Plans" received from the D.O.N. on 10/23/12 at 8:45 a.m., indicated:  "Policy: The facility shall develop a comprehensive care plan for each residentAll staff personnel who provide careshall be knowledgeable of, and have access to, the resident's plan of care."  This federal tag relates to Complaint	TAG	DEFICIENCY		DATE		
	IN00117917. 3.1-35(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 00UZ11

Facility ID: 000149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155245	B. WIN			10/24/2012	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					86TH ST		
CASTLET	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0314	483.25(c)	LSC IDENTIFYING INFORMATION)		TAG	DEFICE (CT)		DATE
SS=G	PRESSURE SOF Based on the con a resident, the fac resident who ente pressure sores do	CS TO PREVENT/HEAL RES INTERPRESENT OF THE PROPERTY OF THE PRO					
	condition demons unavoidable; and sores receives ne services to promo infection and prev developing.	strates that they were a resident having pressure ecessary treatment and ote healing, prevent vent new sores from	E02	14	It is the intent of this facility to		11/12/2012
		ation, interview, and	F03	14	It is the intent of this facility to, based on the comprehensive		11/12/2012
	•	ne facility failed to			assessment of a resident, ensi	ure	
	•	ry services and treatment evelopment of pressure			that a resident who enters the		
	•	the left buttock, stage lll			facility without pressure sores does not develop pressure sor	.00	
	, ,	ck) for 1 resident who			unless the individual's clinical	<del>C</del> S	
	_	thout pressure sores of 3			condition demonstrates that th	ey	
		ed for pressure sores in a			are unavoidable; and a resider		
		-			having pressure sores received		
	sample of 5. (Resident B)  Findings include:  1. The record of Resident B was reviewed				necessary treatment and servi to promote healing, prevent infection and prevent new sore from developing. Describe wh facility did to correct the allege deficient practice for each	es nat	
	on 10/22/12 at 1				resident cited in the deficiency	. 1.	
	_, _, _, _, _, _,	1			Resident B no longer resides a	at	
	to, diabetes mell	ded, but were not limited itus, hypertension, of colon cancer, a			the facility. Decribe how the facility reviewed all clients in the facility that could be affected be the same alleged deficient		
					practice, and state, what action	ns	
	history of compression fracture of the spine, a history of hip fracture with open				the facility took to correct the		
					alleged deficient practice for a resident the facility identified a		
	reduction and internal fixation, agitation, gastro esophageal reflux disease, and				being affected. 1. Skin		
	respiratory distre				assessments were completed	on	

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Event ID: 00UZ11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155245  A. BUILDING  10/24/2012		
155245 — — — 10/24/2012		
B. WING		
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 7630 E 86TH ST		
CASTLETON HEALTH CARE CENTER INDIANAPOLIS, IN 46256		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE	1	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE		
An initial Minimum Data Set assessment, dated 9/29/12, indicated Resident B was cognitively impaired, had trouble  all residents to assess for any areas of skin break down. 2. A Braden Scale was completed for all residents to assess their risk for skin breakdown or pressure		
outeristants, man physican and versus		
appropriate for all residents with		
ambulate, was totally dependent on staff current skin issues and those at		
for bed mobility, was frequently high risk for potential breakdown.		
incontinent of bowel and bladder, and 4. Treatment orders for residents		
required extensive staff assistance for with current skin breakdown were		
activities of doily living reviewed for efficacy and		
Changed as appropriate. 5.		
Progress notes from Wound Care		
An "Admission Nursing Assessment,"  Consultants were reviewed and recommedations implemented as		
appropriate 6 C N A		
admission to the facility, indicated  Assignment Sheets were updated		
surgical incisions to the right hip. No as appropriate. 7. Staff were		
pressure sores or other skin concerns were in-serviced on cause and		
documented on admission. prevention of skin breakdown		
presented by Wouund Care		
A "Bowel and Bladder Assessment,"  Consultants staff and the facility's D.O.N./designee. 8, Licensed		
Skin: No redness." proper measuring, staging and treatments of wounds by Wound		
Care Consultants staff and facility		
Resident B's admission orders and D.O.N./designee. Describe the		
recapitulation of orders for October 2012 steps or systemic changes the		
indicated "Pressure Relieving Mattress." facility has made to ensure that		
Per interview wit the Director of Nursing the alleged deficient practice		
does not recur. T. All new		
is the standard foam mattress used for all charts will be reviewed during the		
residents in the facility.  facility Morning Meeting (Monday-Friday) by the		
D.O.N./designee for proper		
Resident B was sent to the hospital on completion of assessments and		
9/11/12 with symptoms of respiratory care plans. 2. C.N.A. Assignment		
distress, and returned to the facility on  Sheets will be updated on an		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155245	B. WIN			10/24/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
TAG	Presure sores at Nurse's notes for 10:30 p.m., indicated on his low B's nurse's notes	sfer/Referral Form," dicated "Skin: redness  Nursing Assessment," e date of Resident B's ne facility, indicated "Ext coloration Buttock  der, dated 9/22/12, ck Excoriated use buttock q (every) shift ne record indicated no or intervention for risk for that time.  Resident B on 9/30/12 at cated "An area of about m (centimeters) was er buttock" Resident contain no other condition, including				s of by	
		nent Verification" form,					
	· · · · · · · · · · · · · · · · · · ·	dicated Resident B had a					
		sore to her sacral area					
	measuring 3.4 by	y 3.0 centimeters.					
	Treatment was in	ndicated to be "Calmo q					
		tine ointment every shift).					
		ent or intervention was					

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Event ID: 00UZ11

Facility ID: 000149

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155245	A. BUI	LDING	00	10/24/	
		199249	B. WIN			10/24/	2012
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	E CENTER			86TH ST APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	noted.						
	A "Wound Progi	ress Note," dated					
	10/03/12, comple	eted by Advanced					
	Practice Nurse/V	Vound Care Specialist					
	indicated:						
	"Wound Locatio	n: Sacrum.					
	Measurements: 8	3.0 by 9.0 by 0.1					
	centimeters.						
	Etiology (Type):	Pressure					
	Stage: Unstageal	ble/DTI (Deep Tissue					
	Injury)						
	3 37						
	Type of Tissue:	RedFragile					
		C					
	Diagnosis/Plan:	Unstageable-DTI-					
	sacrumDC brie	efs in bed. Upgrade					
	mattress"	10					
	During an interv	iew with the Director of					
	_	on 10/24/12 at 2:30					
		ed that care staff were					
	_	ot use briefs on residents					
	in bed, but that the						
		of specific instructions to					
		r Resident B while in bed,					
		tation of whether this had					
		also indicated that					
		ttress had not been					
		he facility's standard foam					
	upgraucu mom u	ne raemty 5 stanuaru ivani					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE S COMPL	
ANDILAN	OF CORRECTION	155245	A. BUI	LDING	00	10/24/	
		100240	B. WIN			10/24/	2012
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	E CENTER			86TH ST APOLIS, IN 46256		
	·			<u> </u>	Al OLIO, III 40250		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	mattress.			1710			DATE
	matticss.						
	Resident B was	gant haals to the					
		n on 10/07/12 secondary					
		coffee grounds emesis.					
	_	, which include Forensic					
	_	on with documentation					
		cated that on presentation					
		y Room, Resident B had					
		are sore on the right					
		ng 2.5 by 2.5 centimeters					
		g redness of 7 by 5					
	centimeters. The	e left buttock was noted to					
	have "3 small" S	tage ll pressure sores					
	with surrounding	g redness of 5 by 10					
	centimeters. The	resident was admitted to					
	the hospital and	wound care treatment					
	was begun.						
	_						
	Resident B retur	ned to the facility on					
	10/22/12. A "Sk	xin Assessment					
	Verification" for	m on that date indicated					
		Stage 1 pressure sore to					
	the coccyx meas	-					
	_	a Stage II pressure sore to					
		neasuring 1.5 by 0.7					
	centimeters.	neusuring 1.5 by 0.7					
	Committees.						
	Resident R's pro-	ssure sores were observed					
	_	:15 a.m. The wounds					
		consistent with the					
		on the 10/22/12 Skin					
		ification. The resident					
	remained on the	facility's standard foam					

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Event ID: 00UZ11

Facility ID: 000149

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155245		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 10/24/2012				
		133243	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/24/	2012		
NAME OF PROVIDER OR SUPPLIER					86TH ST				
CASTLETON HEALTH CARE CENTER			INDIANAPOLIS, IN 46256						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCI)		DATE		
	mattress. Records indicated a low air loss mattress was ordered on that date.								
	Resident B's record contained no								
	reference to a turning or repositioning								
	schedule. During an interview on								
	_	p.m., the D.O.N.							
	indicated that the facility did not								
	document the ne	ed for turning schedules							
	for residents at risk for pressure sores,								
	either as a physician's order or as a								
	nursing measure. She indicated there was								
	no place in the resident's record								
	designated to do	cument turning or							
	repositioning as	performed. She indicated							
	CNA assignment sheets noted "Turn Q 2								
	hr" (Turn every 2 hours) and it was								
	"assumed" that staff would know to turn residents who were at risk for pressure sores.								
	2. A facility maliary dated 10/24/2011								
	2. A facility policy dated 10/24/2011 received from the D.O.N. on 10/23/12 at 8:45 a.m., indicated:								
	6.45 a.m., muica	icu.							
	"Purpose: To pro	ovide identification of							
	pressure ulcer risk factors and								
	interventions for	the risk factorsOnce a							
	pressure ulcer de	evelops, it can be							
	extremely difficu	alt to heal. The facility							
	should have a sy	stem to assure timely and							
	appropriate evalu	uation							
	Interventions and	d Droventive							
	miter ventions and	a Freventive							

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Event ID: 00UZ11

Facility ID: 000149

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155245	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP	COMPLETED  10/24/2012			
	PROVIDER OR SUPPLIER TON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)  TAG DEFICIENCY)		JLD BE	(X5) COMPLETION DATE			
	MeasuresPlace resident on a minimum of a q (every) hour turning and repositioning program."  This federal tag relates to Complaint							
	IN00117917. 3.1-40(a)(1)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 00UZ11

Facility ID: 000149

If continuation sheet

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